BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **M. DAVID BEN-ASHER, M.D.** Holder of License No. 3724 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-15-0082A** **ORDER FOR LETTER OF REPRIMAND; AND CONSENT TO THE SAME**

M. David Ben-Asher, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 3724 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-15-0082A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of an 80 year-old male patient ("P.T.") alleging failure to follow-up on an abnormal chest x-ray leading to a delayed diagnosis of lung cancer with subsequent death.

4. Respondent was P.T.'s primary care physician since August of 2002. P.T. was also seen by several other physicians for problems including coronary artery disease, degenerative joint disease, diabetes mellitus type 2, obstructive uropathy, resection of an epididymal cyst, and longstanding hypothyroidism. P.T. underwent multiple percutaneous stent placements, a single vessel coronary artery bypass graft, total knee arthroplasties, and other procedures.

5. In 2002, a chest x-ray showed that P.T. had a granuloma in the right base along with nodules suggesting granulomas in the right upper lobe. Chest x-rays taken in 2005 showed no changes.

6. On August 8, 2007, P.T. presented to a hospital emergency department. A chest x-ray showed a right upper lobe pulmonary nodule that was larger than in 2005. The emergency room physician interpreted the x-ray as showing no change, and there was no follow-up. On February 4, 2008, P.T. was again seen in an emergency room for chest pain. A chest x-ray again showed an enlarging density in the right upper lobe. P.T. was instructed to see his physician regarding the possibility of lung cancer. P.T. was also instructed to see his cardiologist within the next few days.

7. On October 21, 2009, P.T. saw Respondent and told him that he had been informed about a spot on his lung in February of 2008. Respondent ordered a chest x-ray. A report was sent to Respondent confirming the right upper lobe mass. Although Respondent saw P.T. on January 20, 2010 and multiple times during the next several months, there is no further reference in P.T.'s chart to the mass until July 23, 2012, when P.T. presented to Respondent with films and reports from a chest x-ray and CT scan from an out of state hospital demonstrating a tumor.

8. Subsequently, appropriate diagnostic studies and treatments were instituted. On February 20, 2013, the tumor and the mediastinal lymph nodes were resected. Post-operatively, P.T. developed severe lactic acidosis with acute renal failure, acute respiratory distress syndrome and ischemia of his intestines. P.T. rapidly deteriorated and died on February 23, 2013.

9. The standard of care requires a physician to immediately follow-up on findings of an abnormal chest x-ray and to order other studies to confirm or clearly deny the presence of a suspected tumor. Respondent deviated from the standard of care by failing to immediately follow-up on the findings of an abnormal chest x-ray taken of P.T. and to order other studies to confirm or clearly deny the presence of a suspected tumor, and by failing to inform P.T. of the abnormal findings, despite numerous opportunities to do so.

10. Actual patient harm was identified in that the opportunity to treat P.T.'s malignant tumor two years earlier was missed as a result of Respondent's actions. P.T. died of complications relating to the surgery performed to remove the tumor.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q)("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 4th day of October, 2016.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

9. ***Respondent has read and understands the terms of this agreement.***

M. DAVID BEN-ASHER, M.D. DATED: 8/29/16

EXECUTED COPY of the foregoing mailed this 4th day of October, 2016 to:

M. David Ben-Asher
Address of Record

ORIGINAL of the foregoing filed this 4th day of October, 2016 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Barbee
Board staff